people helping people — to help themselves

the fiscal 1983 report

Missouri Department of Mental Health

October 1, 1983

To the governor and members of the 82nd General Assembly:

This fiscal 1983 report of the Missouri Department of Mental Health relates the story of an agency attempting to mesh the financial realities of the 1980s with advances in treatment delivery and philosophy.

Three consecutive years of vetoes and/or mid-year budget reductions took an unmistakable statistical toll. From 1981 to 1983, mental health programs absorbed $22.1 million in permanent reductions, or more than 10 percent. The agency has eliminated one of every six employees. The department has closed more than 20 percent of the beds that it operated. We now face withholdings of another $4.6 million in 1984.

The dark clouds, however, have a silver lining.

I can honestly report that the department has refused to compromise the quality of remaining programs, which actually have improved. Major advances took place in gaining accreditation of state facilities. None yet has lost certification by federal Medicaid-Medicare surveyors for inadequate care.

Over the past three years, administrators have used the fiscal crisis to hone the focus of state facilities and programs -- to our benefit. Non-essential and tradition-bound efforts were jettisoned while we attempted to shield the expansion of progressive community programs from damage.

The fiscal crisis also brought renewed attention to the financial management of this department, which remains the fourth-largest employer in Missouri. Aggressive collection efforts increased receipts by 25 percent this year. The department emerged quietly as a major source of general revenue for state government.

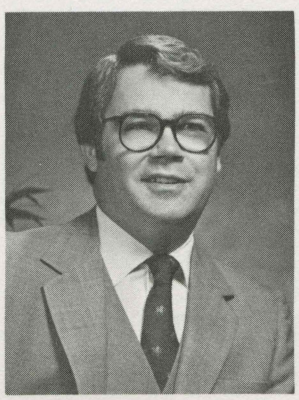
Those collections typify how the times have lowered the bureaucratic barriers that often marred interagency cooperation before. The department could not have implemented a lucrative Medicaid reimbursement plan without the assistance and approval of the Department of Social Services.

Similarly, years of near-neglect fell to the wayside when mental health and corrections officials began working together on a plan to treat psychotic and emotionally disturbed prisoners.

I would be remiss, however, to gloss over the sacrifices of the past three years -- namely the increasing unavailability of services to ill and disabled Missourians.

The department has substantial waiting lists for virtually every program that we operate or subsidize. Too often, the seriously mentally ill must be denied admission to facilities operating at or above capacity. Too often, mentally disturbed or disabled children wait months, even years for appropriate services. Too often, chronic alcoholics must forgo treatment while society runs the risk of violence, abuse and increased social welfare costs.

I trust this annual report will outline how the department has progressed in the face of adversity while underscoring the need for increased services to those Missourians who need our help -- to help themselves.

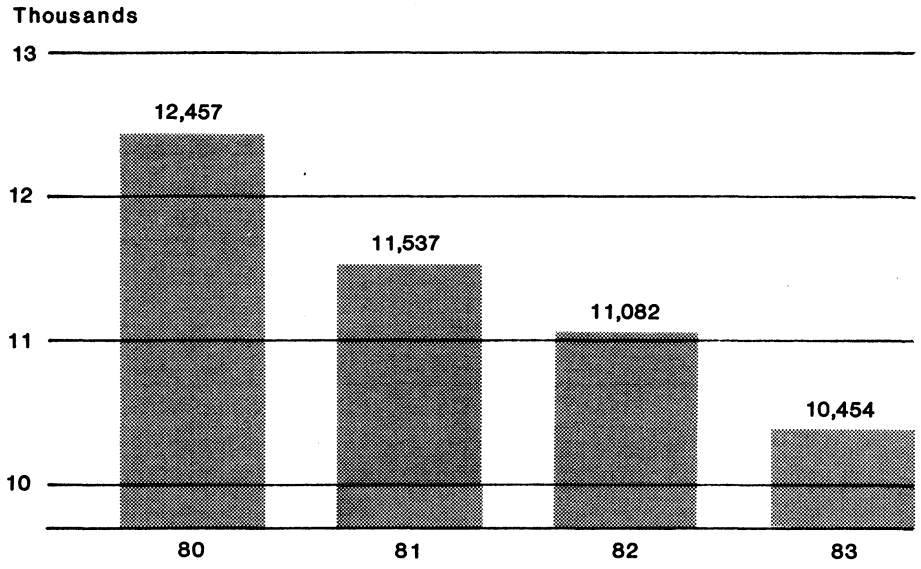


Sincerely,

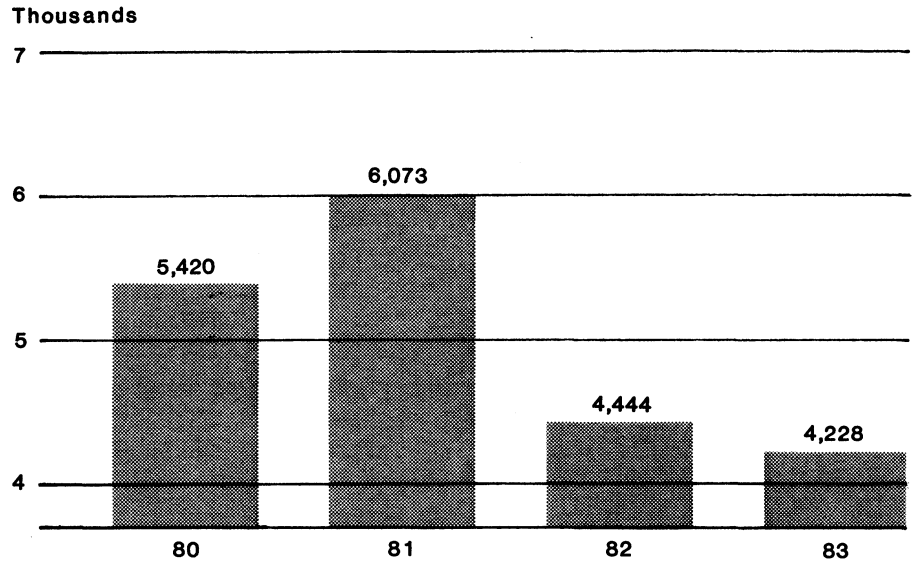
Paul R. Ahr, Ph.D., M.P.A.

Director
Department of Mental Health

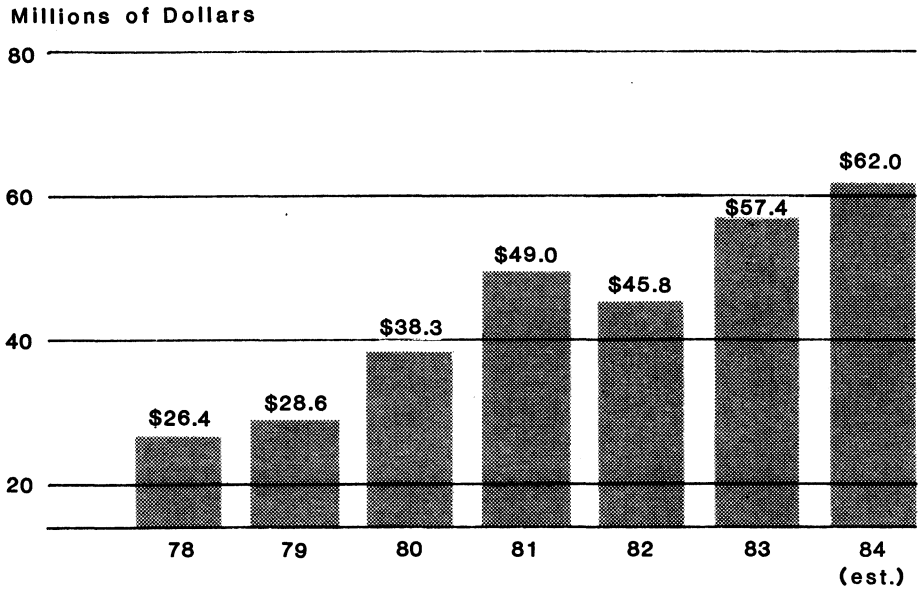
employees at end of fiscal year



average daily census in state facilities



collections to general revenue



the contents

The 1983 annual report of the Missouri Department of Mental Health was produced by the agency's Office of Public Affairs. Randy McConnell, the deputy director for public affairs, was assisted by Mark Roebuck, public information specialist, and Marion Craney, public information officer.

Extra copies of this report are available for $1.00 each. Send checks, made out to the department, to Box 687, Jefferson City, Mo. 65101 to the attention of the Office of Public Affairs.

On the cover: Mary Ann Schreiber, a head nurse, works with two young clients in the children's inpatient program at Mid-Missouri Mental Health Center in Columbia. Photo courtesy of the Columbia Daily Tribune.

habilitating the developmentally disabled

The Division of Mental Retardation and Developmental Disabilities continued to move away from institutional programs toward services delivered in a community setting -- as close as possible to the lifestyle enjoyed by most Missourians.

Nothing less will help an estimated 85,000 developmentally disabled Missourians live to fulfill their human potential.

Central to this evolution in 1983 was the changing role of the state's 11 regional centers located in Albany, Kirksville, Hannibal, St. Louis, Poplar Bluff, Sikeston, Springfield, Joplin, Kansas City, Columbia and Rolla. Those centers serve as the entry and exit points to the state-funded system for persons with developmental disabilities.

Those conditions include mental retardation, cerebral palsy, autism, epilepsy, learning disabilities related to brain dysfunction and those with similar or multiple handicaps. These occur generally before the age of 18 and can be expected to continue indefinitely.

reliance on large, long-term care centers is decreasing

At these centers, the developmentally disabled are diagnosed. Professionals then write individual habilitation plans that will help the person gradually progress to higher levels of functioning.

The state subsidizes a spectrum of care for developmentally disabled persons, such as medical services and pre-vocational training. But the key word is "habilitation," a term that covers speech and physical therapy, training in such life skills as eating and toileting, and mobility instruction that allow the client to function more independently.

The regional center may refer clients needing intensive help to the four state habilitation centers or the similar St. Louis Developmental Disabilities Treatment Center. Each of these facilities in Marshall, Nevada, Higginsville and St. Louis is developing areas of expertise. Nevada, for example, focuses on care for geriatric clients. Marshall serves those needing specialized medical care.

But reliance on these long-term care facilities has decreased steadily. National research indicates that such severely and profoundly retarded clients progress as much or more in smaller community facilities. The division also has responded to budget reductions by limiting the census of these facilities. Those restraints force potential clients, except for emergency cases, to wait an average of 18 months for admission. When fiscal 1974 ended, the state cared for 2,341 clients in the habilitation centers, then known as school-hospitals. Only 1,934 were receiving care there on June 30, 1983, even though the state added the St. Louis treatment center during those nine years.

the regional centers

In the 16 years since the first regional centers were established, they also have provided direct services to short-term residential clients. Only two of the centers -- St. Louis and Central Missouri -- rely solely on buying services and monitoring client care by private agencies. The others at one time had beds for as many as 40 clients in addition to community contracts, and Central Missouri used Marshall's beds until the regional center was transferred to Columbia in November 1982.

the regional centers' beds, too, were curtailed

That residential role changed dramatically in fiscal 1983. Faced with a $1.3 million mid-year withholding from 1983 appropriations and the promise of further cuts in core spending for 1984, division officials decided to reduce the bed capacity of all regional centers to no more than eight. By the end of the year, the residential population of the nine centers totaled only 102 -- down from 189 when 1983 began and from 315 in 1975.

The division would attempt to cushion the cutback in residential services through increased contracts with private agencies, particularly for parents or guardians who kept these clients at home, but needed occasional respite by placing them elsewhere for short periods.

The General Assembly approved a $1.4 million increase to purchase community services for the developmentally disabled in fiscal 1984. Division officials estimated that amount was less than necessary to cover the service gap. As yet, worst-case scenarios haven't developed although the centers' residential census reached the lowest point since the regional system was fully operating. However, the waiting list for placement or day services hovers at 1,100 at the St. Louis Regional Center, and another 1,000 statewide face delays or simply lack available services.

Overall, the residential census changes at the habilitation centers and regional centers allowed the division to spend only $57.9 million on inpatient programs for the developmentally disabled in fiscal 1983. That amount fell short of the total for fiscal 1981, when the state's general revenue shortfalls became apparent.

community services

small community programs serve clients close to home

Changing the role of regional centers and diverting fewer clients to large facilities were made possible only through the dynamic growth of small, community-based programs across the state in recent years. These programs -- such as foster and group homes, supervised apartments and day therapy -- provide habilitation in least restrictive environments, as prescribed by federal and state laws. The programs also offer habilitation as geographically accessible to clients as possible.

The growth in community services, in large part, springs from two sources: the county mill tax levies and federally-funded developmental disabilities grants, which are awarded with the advice of state and regional councils.

three more counties approved taxes to help the disabled

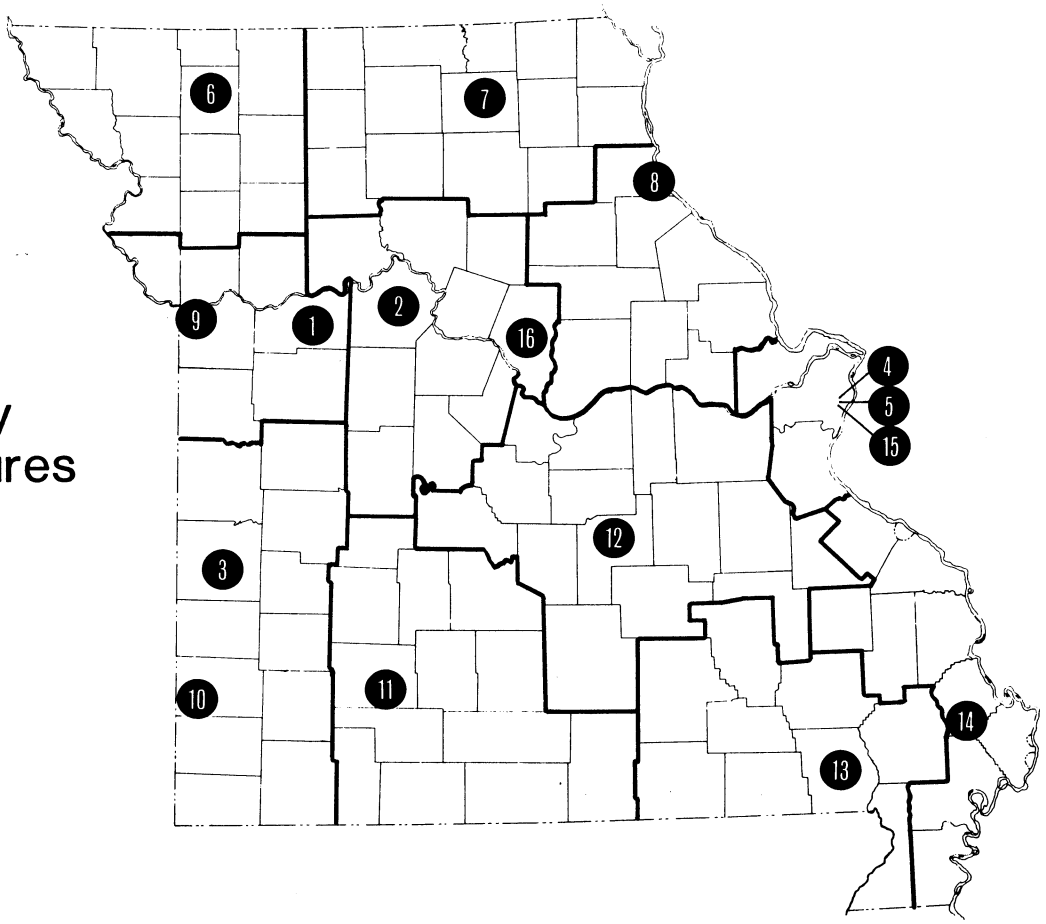
In 1969, the General Assembly authorized counties to aid the handicapped by levying a property tax of up to 20 cents per $100 of assessed valuation. During the first five years under the law, only two counties adopted the tax. But in 1974, the federally-funded and -mandated Missouri Planning Council for Developmental Disabilities — also an advisory group to the division -- began to aggressively press for passage of more county levies.

Working with regional councils, the state council closed its books in 1983 with 56 of Missouri's 115 counties levying the so-called "Senate Bill 40" tax, administered by nine-member local boards.

Those tax revenues have been instrumental in building numerous group homes and sheltered workshops as well as starting or expanding day programs for the developmentally disabled. Typically, when the county board begins a program, the state will support its operations by paying part or all of the cost for clients referred there by the regional centers.

During calendar 1983, these 56 county boards will collect an estimated $12 million in property taxes on behalf of the disabled; 80 percent of Missourians will have access to these county-supported services. In fiscal year 1983, Cooper, Montgomery and Howard counties joined the honor roll of local jurisdictions voicing their commitment to the developmentally disabled by voting to levy the tax.

division facility facts and figures



the planning council

The state planning council continued its drive toward establishing a full continuum of services by helping award $488,979 in federal Developmental Disabilities Act grants, largely as seed money for new services. Those grants ranged from $58,900 to help the Sunshine Children's Home establish a group home in the Carthage area of Jasper County to $9,330 to buy training equipment for the Sherwood Center for the Exceptional Child in Jackson County. The center will use the equipment to help disabled youth adjust to the tasks and routines of sheltered employment.

The council's zeal on behalf of the developmentally disabled was confirmed when a voluntary federal survey found that the council and its staff "present a sense of dedication and sincere interest in carrying out the mandate of the developmental disabilities law. The council is serious in its position as serving as advocates for persons with developmental disabilities."

The review indicated that the council scored high in all areas except administration, and the shortcomings there were beyond its control. Vacancies deprived the council of sufficient consumer representatives, and the federal review team questioned the fact that eight of the then-15 members were serving well past the expiration dates of their terms. The council, which has a legal complement of 20 members, is appointed by the governor.

#	Facility	Daily Rate(1)	Average Daily Census	Clients Served(2)	Per capita funding (5)
	Habilitation center				
1	Higginsville	$ 92.30	226	284	n/a
2	Marshall	85.31	543	1,289	n/a
3	Nevada	125.50	376	472	n/a
4	Bellefontaine	99.05	417	456	n/a
5	St. Louis DDTC	81.46	307	1,034	n/a
	Average	96.72			
	Regional center				
6	Albany	$128.59	9	552	$5.47
7	Kirksville	199.73	13	532	7.00
8	Hannibal	155.06	11	797	7.32
9	Kansas City	158.26	16	1,472	1.95
10	Joplin	129.74	14	768	4.56
11	Springfield	94.71	7	775	3.51
12	Rolla	84.44	14	634	3.07
13	Poplar Bluff	115.78	16	648	7.35
14	Sikeston	90.40	21	650	5.37
15	St. Louis	(3)	0	4,103	3.48
16	Central Missouri	(3)	0	(4)	1.94
	Average	124.31			

(1) Figures for habilitation centers are rates reimbursed under the Medicaid program. Figures for regional centers are final 1982 numbers; because of employee layoffs and the sharp cutback in beds, numbers aren't yet available for 1983.

(2) This figure represents clients served unduplicated by facility.

(3) St. Louis and Central Missouri operate no inpatient beds.

(4) The information system counted these clients in the Marshall total.

(5) Number doesn't include end-of-year adjustments.

the withholdings

The division's commitment to community services was disrupted in fiscal 1983 with mid-year withholdings by the governor of appropriations previously approved by the General Assembly. Altogether, $808,000 of projected spending was withheld from regional centers and the community services budget.

The bed reduction came with no little pain. The division was forced to lay off more than 100 workers as 150 positions were eliminated. Many were longtime employees with outstanding work records. The decision also had serious economic and community-relations ramifications in such cities as Albany, where a relatively small state facility played a major local role.

the division used withholdings to increase equity in community funding

But more than half the reduction came from contracts with private agencies. The division chose to deal with this decision by increasing the equity among the state's 11 geographic areas, each of which has a regional center. Regions with center budgets and contract allocations exceeding $5 per capita were decreased by 5 percent. Others with more than $3 lost 3 percent. Those below $3 weren't affected. As a result, the Poplar Bluff region at $7.74 per capita suffered a relatively large reduction while Central Missouri and Kansas City regional centers proceeded with no budget changes.

State habilitation centers continued to adapt to the withholdings with gradual reductions in census and staff as they accommodated the elimination of $508,000 in funding and, largely through attrition, 42 jobs.

But the funding shortage did little to dampen the drive to upgrade services to division clients in the community placement program, which provides residential services. In recent years, the division has attempted to withdraw clients from boarding and nursing homes that don't have adequate living conditions or don't provide proper habilitation.

During the course of the year, the number of division clients in skilled and intermediate care nursing homes dropped from 642 to 567. Far more normal group homes in the community increased their division-sponsored clientele by 121 to 1,158 during that time. The agency also increased its initiatives to develop more contracts for foster care and other arrangements that place developmentally disabled persons in natural homes. For example, the division developed 66 new foster homes with space for 166 clients. The supervised apartment program increased from 68 to 90 clients.

the move to transfer clients from nursing homes continued unabated

Overall, the placement program spent $20.3 million, or an increase of $2.5 million from the previous year. The number of clients served in residential settings increased from 3,760 on June 30, 1982 to 3,950 one year later.

the evolving St. Louis center

From a facility viewpoint, the St. Louis Developmental

Disabilities Treatment Center experienced the most eventful year. The center was finally able to begin moving clients off the grounds of St. Louis State Hospital, which had served as the center's temporary home since 1975.

The center began as a 94-bed facility serving the more medically needy clients of two large habilitation centers and five regional centers. But when habilitation programs also became eligible for federal Medicaid reimbursement, the center expanded to include that intensive programming. By 1979, the center had grown to 300 clients, largely because of the closing of nursing homes where the division had placed residents.

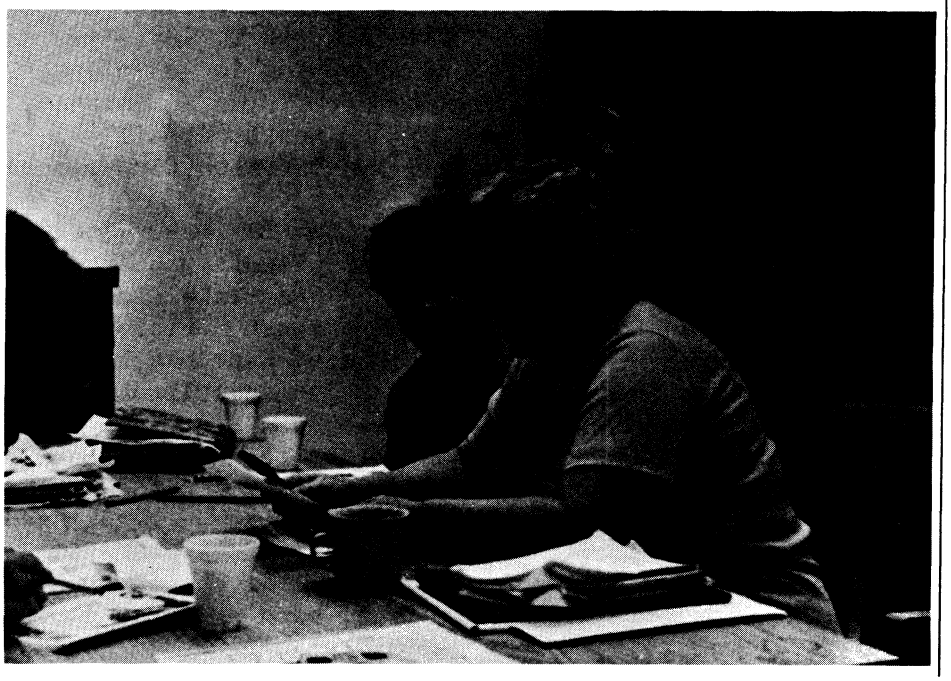
But it quickly became apparent that the setting on the state hospital grounds was unacceptable to parents, state and regional advisory councils, the department, area legislators and the governor. In early 1979, the legislature appropriated the first funding to build new sites for the center.

Opening in early 1983, after a state investment of $6.5 million, were the 46-bed Midtown Habilitation Center in St. Louis and the 72-bed South County Habilitation Center. Midtown serves the profoundly mentally retarded who have multiple handicaps in a facility near the St. Louis University medical complex and Cardinal Glennon Hospital.

South County serves more physically able clients who are likely to move into community programs more quickly. The center is composed of nine homes clustered around an activities and administration building with ideal physical facilities for the handicapped.

The department and commission are seeking funding for the final two phases of the transfer in the fall and spring of the 1984 fiscal year. The final two facilities, located in St. Louis County, will complete the transfer of developmentally disabled persons from a hospital setting to more normalizing environments.

Midtown and South County centers opened their doors



rehabilitating the alcohol and drug abuser

The Division of Alcohol and Drug Abuse operates on the smallest budget of the department's three major programs by far, but confronts the state's most prevalent public health problem.

A study of Missouri's substance abuse prevalence found that one in 11 or 438,000 residents suffer from alcohol or drug abuse. Hundreds of thousands of their family, friends and work colleagues suffer with them. White male alcoholics between the ages of 30 and 60 continue to dominate the division's caseload. But the prevalence of substance abuse leaves no segment of society untouched.

Professional women, climbing the executive ladder and confronting stresses once largely reserved for men, increasingly are subject to alcohol abuse. Housewives, often unskilled and less fulfilled after children leave the home, figure prominently in the numbers of Missourians abusing prescription drugs.

Well-to-do suburban teenagers "speed" their way through the day and "down" themselves to sleep at night -- or simply consume whatever pills are available. Youngsters increasingly are entering detoxification and residential alcohol rehabilitation programs that once were viewed as the sphere of the "wino."

substance abuse leaves no segment of society untouched

The division, of course, doesn't regard state-funded programs as the lone solution to growing substance abuse. The alcohol and drug abuse plan anticipates that the private treatment sector, abetted by employee assistance plans and health insurance coverage, will provide services for half the caseload that seeks treatment each year.

Fortunately, the private sector's efforts grew rapidly in 1983. The division's employee assistance network reported that coverage more than doubled to 142,314 workers and family members participating in 141 plans. These figures don't include larger employee assistance plans funded by Anheuser-Busch, Southwestern Bell Telephone, Southern Pacific and the Chrysler Corp., among others.

But the division continues to offer far fewer services than needed by the 43,800 potential clients who are considered its responsibility under the state alcohol and drug abuse plan for 1983. Through program revisions and a federal funding windfall, the division was able to increase its number of clients served (unduplicated by agency) by 10 percent, but only to 15,923.

The increase, as much as anything, though, reflects the doldrums of fiscal 1982, when clients and treatment funding plummeted. The waiting list for rehabilitation programs increased 81 percent to 242 persons statewide during the year. During April, the number peaked at 374.

The unexpected federal windfall, born amid budget cuts in the alcohol, drug abuse and mental health block grant,

will help allow the division to maintain an $11 million level of treatment funding through fiscal 1985, even if state funding doesn't increase. State support will remain static in fiscal 1984. Looming ahead, though, is a likely shortfall of $600,000 in available fiscal 1987 federal funding.

Also helping to maintain funding levels are major structural changes in the division's administration. Since 1980, reorganization has reduced spending there by 48 percent through personnel cuts.

administrative costs have been reduced 48 percent

a program overhaul

In another facet of turning less into more, the division continues to convert money for hospital alcohol abuse programs into contracts for less expensive care by community agencies. Of 59 programs offering state-subsidized substance abuse treatment in 1983, state hospitals operated only six.

Funding for those alcohol and drug programs fell from $4.6 million in fiscal 1981 to $2.8 million in 1983. Those remain because the state hasn't found a competitive bidder to operate under contract. But the division expects to transfer another hospital program at Mid-Missouri Mental Health Center to a community agency in 1984.

The division has found that conversion of detoxification hospital beds into community contracts has made three times the previous level of services available. The division continued to stress rehabilitation at less intensive levels, which frees up services for more clients without increasing costs.

The number of detoxification beds doubled in 1983 from the previous year of transition to community-based services, but the division expects to cut the number from 132 to 120 in 1984. Beds at residential treatment centers, which provide post-detoxification services, increased from 386 to 460 in 1983. The leap forward, though, came in outpatient care, which jumped from 97,469 units of counseling to 141,713.

As a minimum program, the department and the State Advisory Council on Alcohol and Drug Abuse want public detoxification, residential treatment and outpatient counseling available in all 26 service areas of the state. (These areas correspond with the service areas for psychiatric programs.) But nine areas lacked one or all three levels.

nine areas lack one or all three basic services

For example, St. Louis County and its 974,000 residents have no state-subsidized detoxification and residential programs. The Northland area of Clay, Platte and Ray counties has no public alcohol abuse rehabilitation programs of any kind. The same applies to the Sikeston area.

And expanding programs for the general population won't meet the rising and special needs of women, minorities, children, adolescents and the elderly, who are the targets of initiatives proposed in the state alcohol and drug abuse plan. The Mental Health Commission

has endorsed doubling the current alcohol and drug budget to increase the volume and types of services across the state.

do they get better?

The commission and division began to emphasize analysis of the effectiveness of substance abuse programs in 1983. For example, in an early initiative, the division director established a five-member task force to re-evaluate the state methadone program for narcotic users.

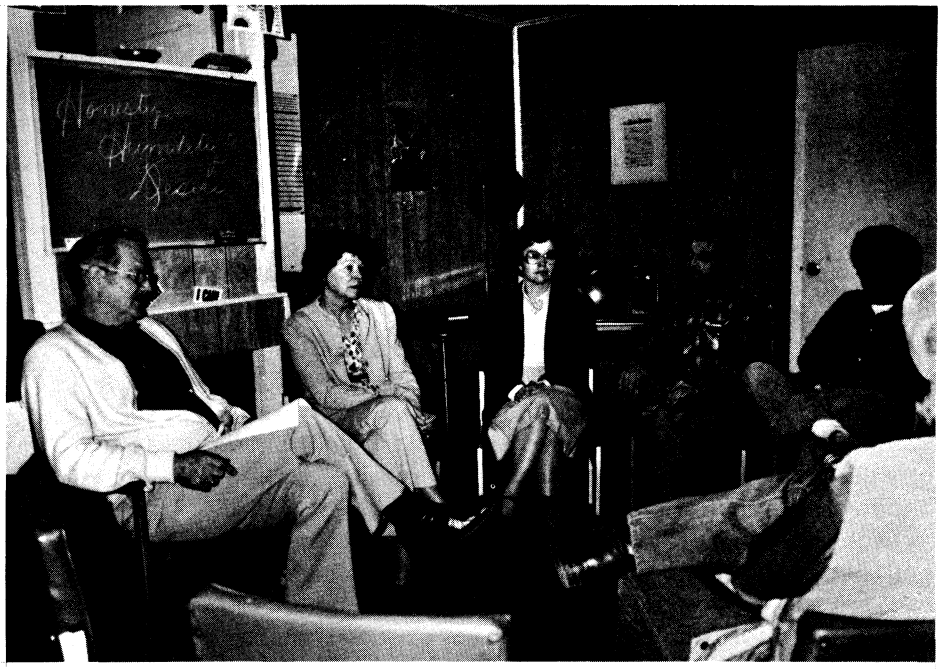
The program is dogged by three major problems:

-- The diversion of methadone into illegal markets, which has accompanied the growth of such treatment since it was introduced in 1965.

-- Ethical reservations about the substitution of a legal, addictive drug to treat abuse of an illegal narcotic, such as heroin, opiates and similar synthetic drugs.

-- Extensive government regulation of methadone.

The state funds methadone treatment -- either in state facilities or under contract -- for 453 clients, or 32 percent of its drug abuse caseload. The services are available at one Kansas City clinic and three in St. Louis. As in the rest of the nation, the division has decreased reliance on methadone treatment after a peak of 750 such clients in 1975. But the state still spent almost $900,000 on the program in 1983, or almost $2,000 per client.



The division staff also began assembling information on if and how clients were improving their lives and responding to treatment. The staff found that slightly more than half (51.7 percent) were completing treatment through one or more types of programs.

A survey of 3,233 clients who completed treatment in fiscal 1982 also found that:

-- One-fifth had completed or enrolled in education or vocational programs when they were discharged.

-- 45 percent were employed, and one-eighth who had been unemployed before treatment now had jobs.

-- One-fourth of those getting jobless benefits before treatment were supporting themselves with employment upon discharge, and 22 percent of clients receiving welfare had done the same.

-- More than three of every four alcohol abuse clients had not had a drink for more than 30 days.

-- Clients completing treatment were subject to 65 percent fewer arrests than before.

studies found treatment cut social welfare costs

special projects

During the year, the division began an array of activities designed to strengthen the ties with organizations that ought to be affiliated closely with state substance abuse programs.

Of keen interest is the criminal justice system that each year deals with thousands of persons whose problems stem from substance abuse. A special task force, composed of state officials, judges and law enforcement officers, reported that all agencies concerned should take steps to coordinate services. The need has been intensified for two consecutive years by increased legal sanctions enacted for those convicted of drunken driving.

The task force concluded that stiffer punishments alone wouldn't affect the incidence of drunken driving greatly. Instead, the members called for a comprehensive program that provides for increased public education and treatment programs. The group also endorsed more services to the hard-pressed corrections and probation-parole system. Probation and parole, for example, had to discontinue its urinalysis testing of chemical substance parolees during the year because of budget cuts. The panel asked the department to make its facilities available for continuing the program.

the AMA cited Missouri for a model prescription drug campaign

The American Medical Association cited state agencies, including the Division of Alcohol and Drug Abuse, as a "model for the nation" in coordinating a campaign to limit abuse of prescription drugs -- a problem that makes marijuana and heroin pale in comparison, based on overdoses and deaths. The effort has drawn together health licensing boards, enforcement authorities and treatment programs across state government into a team with the professional health associations.

Continuing in 1983 was the nationally lauded program to alert pregnant women to the dangers of consuming alcohol while they are pregnant. The state and regional advisory councils served as the coordinator of the fetal alcohol syndrome program while also heading state efforts on national campaigns aimed at teenage drinking and abuse by working women.

treating the mentally ill

It's called the loneliest illness of all.

More than one of every 40 Missourians -- or an estimated 129,800 persons -- are believed to suffer from the three major psychiatric disorders alone: schizophrenia; organic psychoses; and severe depression.

Although the state relies on private agencies and practitioners to provide the bulk of care for these individuals, the Division of Comprehensive Psychiatric Services ranks as the largest single provider. In fiscal 1983, the division treated or purchased care for 56,700 clients. A decline in direct state care and placement clients was offset by a slight increase in treatment purchased from private agencies.

the community movement has drastically altered the picture

Public perception of this system often centers on state-operated facilities, which provided almost all public mental health care until 25 years ago. The state still operates five mental hospitals, three community mental health centers, two children's psychiatric hospitals and a new mental health services center.

Hospitals continue to play a major role when their services are the most appropriate or the only programs available to the mentally ill. With their expensive task of treating the most severely and sometimes dangerously mentally ill, the hospital inpatient programs spent $83 million of the state's $119 million budget for psychiatric services in 1983.

But the introduction of stabilizing medications and the community mental health movement have drastically altered the overall picture.

The average daily state hospital census peaked at 11,753 in 1956. By 1983, the daily census had declined to 2,133 even though Missouri added three state-operated community mental health centers and two children's psychiatric hospitals with inpatient beds during the interim. The emphasis clearly has shifted from inpatient hospital care to far less expensive treatment in the community -- close to jobs, family and friends.

community treatment

treatment mainly takes place close to jobs, family and friends

The division continued to refine the administrative agent model, first introduced two years earlier, that takes into account that shift in the delivery of care. The division has broken the state into 26 service areas, each of which has an "administrative agent."

These agents distribute and monitor funding for state-subsidized community services to outpatient clients and, ideally, serve as the entry and exit points into the state mental health system. In that fashion, clients who don't need intensive hospital care are diagnosed early and steered to less expensive and restrictive outpatient therapy and other community services.

Of the 26 agents, only nine are state-operated facilities; the others are community, not-for-profit mental health or counseling centers that care for

non-subsidized patients as well.

These agents may contract with other agencies to actually provide care. So, while St. Joseph State Hospital acts as the agent for much of northwest Missouri, most outpatient treatment is provided by the private Family Guidance Center of St. Joseph. In fiscal 1983, the division set aside $12.2 million in state and federal funds for the purchase of outpatient care of more than 27,000 new clients through these 17 private agents in addition to their continuing caseloads.

Community services in the 26 service areas operated at one of three levels during fiscal 1983. A core-level clinic, available in eight areas, provides basic outpatient programs of emergency intervention, screening, counseling, medication for former hospital patients and information and referral.

Intermediate centers, operating in two areas, also offer day treatment programs and residential services, such as psychiatric group homes. Full service centers in the other 16 areas operate acute inpatient hospital beds as well.

a glaring gap was closed with the opening of Great Rivers

The division and private agents have agreed on a funding goal of at least $5.25 per capita, compared to a statewide average of $3.22 in 1983. During the year, only seven of the 26 agents had allocations exceeding $5, and five of those were state-operated.

The division took an historic step toward correcting the most glaring gap in the state's community services when department Director Ahr announced, in May, the establishment of Great Rivers Mental Health Services in Clayton. The center supplanted the former outpatient clinic operated by St. Louis State Hospital that served 1,600 St. Louis Countians.

Before, county residents had been allotted 54 cents each for community services for its 974,000 residents. The change makes $1 per capita available by adding federal funds and reallocations from the state hospital budget. Great Rivers, over time, will shift from providing direct care to purchasing and monitoring treatment by private agencies. The program may serve as a model for other regions now served by state facilities.

care on the campus

The "back wards" are no more.

More than ever, state psychiatric facilities are far removed from the old sprawling institutions that mixed social misfits with the actively psychotic and chronically ill.

state facilities are smaller, more treatment intensive

Sunshine and colorful furnishings brighten the largely semi-private rooms and common areas. Individual treatment plans prescribe a regimen of therapeutic activity for each client and regulate the use of behavior-altering drugs.

Partly by design and partly from budget restraints, state psychiatric facilities have emerged with leaner, more sharply defined programs over the past two decades and, particularly, the past four years. State hospital admissions generally are limited to the seriously

mentally ill, including those who are dangerous to themselves or others.

No longer are the wards cramped with patients who have grown old in state hospitals. Those elderly patients without major psychiatric needs generally have been transferred to nursing homes. Those who remain participate in active programming. The facilities, with limited exceptions, also have discontinued substance abuse programs and the inappropriate mixing of those clients with the mentally ill.

Increasingly, the facilities provide treatment for those mentally ill persons for whom the private sector cannot feasibly or would prefer not to serve. These difficult clients also are the most expensive to treat because they require intensive staffing.

They include aggressive children, criminal commitments, persons with multiple handicaps and those whose psychotic conditions will require long-term care to stabilize.

The 10 state inpatient programs absorbed mid-year budget reductions for the third consecutive year. Some were asked to incorporate two sets of budget cuts. Following criteria adopted by the Mental Health Commission in 1981, the division concentrated on reducing the number of services rather than their quality in absorbing a $1.6 million withholding of general-revenue appropriations by the governor in October 1982. The admissions criteria were further tightened, and outpatient services were curtailed. The average daily hospital census fell from 2,208 to 2,133, or more than 3 percent during the year.

increasingly, admissions in St. Louis occur only under court order

Complaints grew about the difficulty of getting a severely mentally ill person admitted to a state facility.

On some days, neither Malcolm Bliss Mental Health Center in St. Louis nor St. Louis State Hospital -the only two public inpatient facilities for adults in the area -- would admit patients unless they had been committed involuntarily by a circuit court. Similarly, Nevada State Hospital was strained by inpatient caseloads that reached 110 percent of capacity on occasion.

Originally designed for no more than short-term, acute-care inpatient units, the three state community mental health centers faced increasing pressure to keep intermediate-care patients who might need several months of care. State hospitals, built to accommodate those patients, simply couldn't meet the demand.

The division moved to ease the situation in late fiscal 1983 when it obtained emergency appropriations to open a 28-bed intermediate-care unit at Western Missouri Mental Health Center. Overall, division officials estimate that an extra 200 beds are needed to provide acceptable capacity within the system. The Mental Health Commission has asked for funding to bridge that gap in its fiscal 1985 budget request.

The division relies on Medicare-Medicaid standards, which qualify the state for 60 percent federal reimbursement for eligible patients, to set minimum direct-care staffing levels in facilities. The agency

consequently can match staff cuts generally with reduced patient census. No such mechanism exists, however, for administrative and support staff.

Recognizing the need for uniformity in support staff patterns after three years of ad hoc budget cuts, the division set interim standards for those positions in March 1983. Their implementation required the elimination of almost 140 posts in nine psychiatric facilities. Affected areas included dietary, housekeeping, laundry, maintenance, clerical and general administration. The savings are earmarked for expanded community services and facility treatment needs in fiscal 1984.

division facility facts and figures

Facility	Daily Rate(1)	Average Daily Census	Clients Served(2)
State hospitals			
Fulton	$106.80	545	2,600
Nevada	88.38	150	1,630
St. Joseph	132.29	301	2,926
Farmington	131.99	313	3,032
St. Louis	112.06	415	6,245
Average	120.91	-	-
Children's hospitals			
Woodson	230.13	28	(3)
Hawthorn	224.02	37	(3)
Average	226.93	-	-
Mental health centers			
Malcolm Bliss	158.68	138	6,847
Mid-Missouri	186.61	61	3,581
Western Missouri	144.13	145	4,414
Average	156.69	-	-

(1) These daily rates are the amounts reimbursed under the Medicaid program as of April 1, 1983.

(2) This number represents the clients served unduplicated by facility.

(3) The department's information system still counts Woodson clients as part of the St. Joseph State Hospital total and Hawthorn clients in the St. Louis State Hospital total.

community living

Outpatient and hospital inpatient care form the extremes of a continuum of care that should exist to help the mentally ill adjust to post-hospital life --or let the emotionally disturbed receive degrees of supervised treatment without entering a hospital. Depending on the

level of need, these community placements can range from nursing and boarding homes to psychiatric group homes and supervised apartments.

placement fills the gap between hospitals and outpatient care

When the 1983 fiscal year ended, the division was monitoring 4,337 contracts for residential services in 463 facilities as well as 1,230 to provide therapy for those clients. Seven hundred of those placements had been made at no cost to the state because clients had other resources that are tapped first. The remainder cost the department budget a monthly average of $193.07 each. Over the year, the placement program cost the division $12.1 million, up considerably from $9.8 million the previous year.

The paradox of decreased placements at higher cost is explained by one trend: the division's considerable progress in upgrading improper placements.

Nursing homes, the prime beneficiaries of the early deinstitutionalization push, generally are appropriate placements only if medical needs outweigh psychiatric concerns. Many geriatric clients should be placed in skilled or intermediate care nursing homes, particularly if they exhibit the physically debilitating effects of long-term institutionalization.

The same cannot be said of the increasing population of young, physically healthy, but chronically mentally ill adults. They are not appropriate to mix with an aged, sickly population, and their therapeutic needs are far more intensive. Consequently, the declining reliance on nursing homes in 1983 is viewed as an encouraging sign. Compared to June 30, 1982, the year ended with more than 8 percent fewer clients in skilled or intermediate nursing homes. Clients in boarding homes dropped by almost the same percentage.

apartments, group homes allow young adults to re-enter the mainstream more quickly

Placements in supervised apartments and psychiatric group homes are far more likely to allow these young and middle-aged adults to re-enter the social and economic mainstreams and avoid a lifetime of institutionalization at tremendous personal and governmental cost. Many gradually can learn to cope with the stress of everyday life and develop the routine skills that we often take for granted.

During fiscal 1983, the number of apartment placements rose almost 16 percent to 481. Similarly, placements in psychiatric group homes increased to 106. Equally encouraging, contracts for therapy alone increased slightly even though the total placement count declined. The trend indicates that fewer placement clients are living in facilities without adequate programming.

community impediments

Serious obstacles remain, however, to developing an adequate placement program for the mentally ill. The first issue is governmental financing. The current structure creates tremendous pressure on division officials to place clients in settings that are less costly to the department budget, but more costly, overall, to the taxpayer and less appropriate for the clients' needs.

The main culprit: the joint federal-state Medicaid program, which covers expensive nursing home care for eligible clients. The federal government reimburses 60 percent of the cost, and the Department of Social Services -- not mental health -- pays the rest.

Also operating to the financial advantage of nursing homes is the state cash grant program for non-Medicaid nursing and boarding homes, which is the only program of its kind in the country. By tapping these sources, the Department of Mental Health can stretch its limited placement finances, but the past shows that this approach can come at a cost to client needs.

financing creates obstacles to proper placements

On the other hand, the department must assume the full financial brunt of less expensive and less restrictive placements in smaller group homes and apartments unless the client has assets or entitlements like disability or veterans benefits.

In a nutshell, the financing system creates disincentives to placing clients in less restrictive and more therapeutic environments. The department will play host to a national meeting in the fall of 1983 on how to obtain a waiver of Medicaid regulations that now prohibit reimbursement for treatment in Missouri's psychiatric group homes. If the department can obtain a waiver, the federal government would begin shouldering more of the burden for community psychiatric care.

The mentally ill, much more than the mentally retarded, also face less community acceptance of the need for a balanced range of services with local financial support. Voters in only nine counties, generating an estimated $2.9 million this year, have passed local property taxes to fund services and residential programs for the mentally ill. Support has been strong in the Kansas City, Cape Girardeau and Joplin areas. But the meager showing elsewhere typifies the roadblocks to and misperceptions of community facilities for the mentally ill.

on behalf of criminal justice

mental health, corrections were drawn together to help ease prison overcrowding

Coming to the fore in 1983 were services for persons committed to either the mental health or corrections systems by the courts. Both agencies began developing plans to provide more professional care for the mentally ill who have engaged in crime -- persons who often fall between the cracks.

Especially few services were provided to inmates in the custody of the Department of Corrections, either by that agency -- which has only 30 psychiatric beds in its lone hospital -- or the Department of Mental Health. Until mid-1983, the Division of Comprehensive Psychiatric Services focused on two types of forensic services: pre-trial evaluations to determine competence and responsibility; and treatment of clients committed by the criminal justice system to mental health rather than corrections.

Department officials continued to show steady progress in decentralizing pre-trial psychiatric exams, which once were conducted primarily at outstate Fulton State

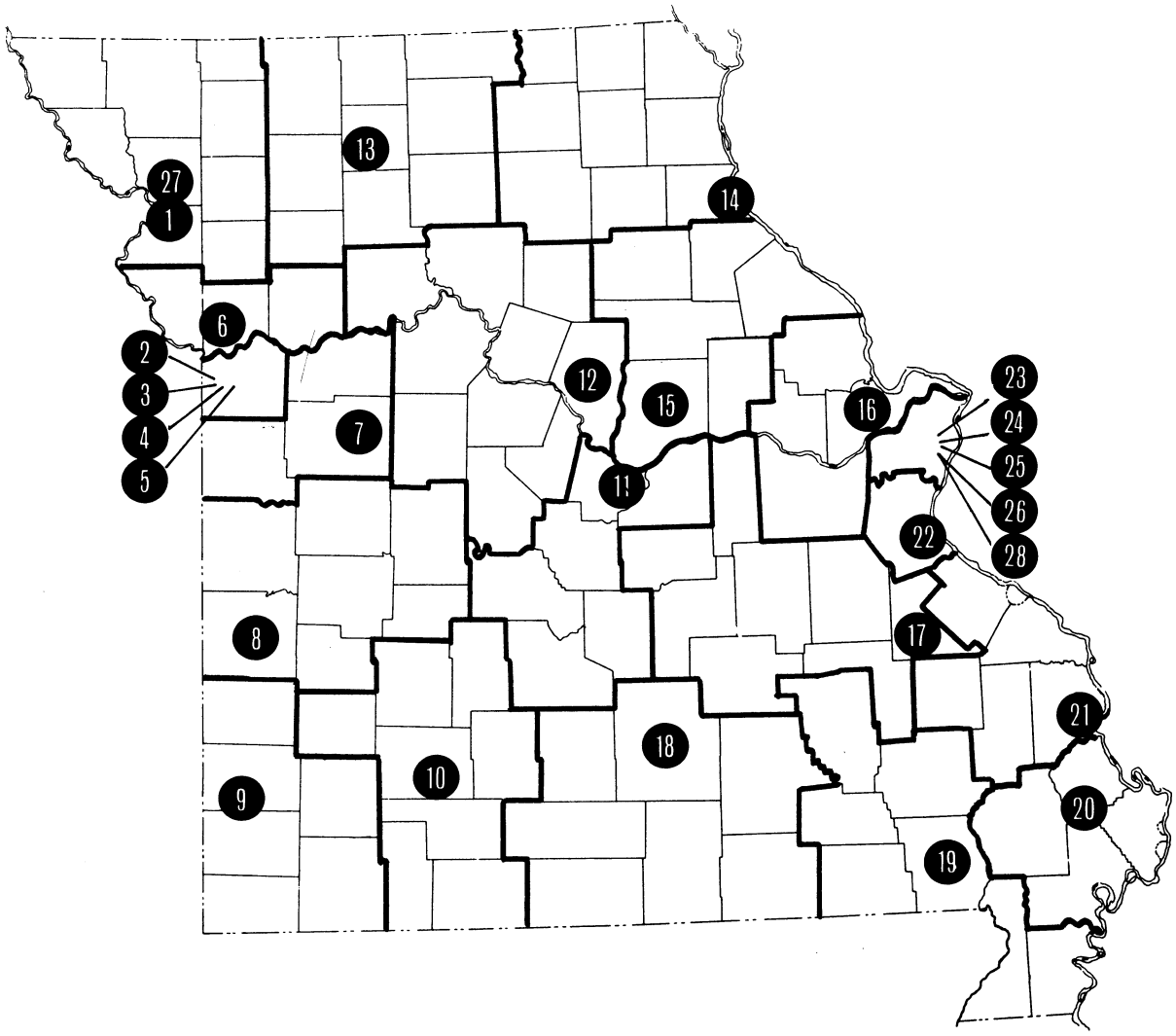
Hospital rather than near the metropolitan courts where most cases originate. Fulton now conducts less than 20 percent of the exams. All 10 inpatient psychiatric facilities now review defendants before trial, under court orders, in their service areas.

By May 1983, the department operated 310 forensic psychiatric beds for the acute, residential and long-term care of criminal commitments. Typically, these clients were found not guilty by reason of mental disease or defect, incompetent to stand trial or guilty under the now-repealed sexual psychopath statute.

The majority of forensic clients committed to the department receive inpatient services at the maximum-security, 215-bed Biggs Forensic Center at Fulton State Hospital. Cremer Forensic Center at Fulton has 50 beds for persons who no longer need the maximum-security and intensive treatment of Biggs.

In fact, the most-improved Cremer clients have ground passes and even work in the community. Farmington State

division facilities and



Hospital developed a unit to accept transfers from Cremer. Malcolm Bliss Mental Health Center in St. Louis also operates 20 forensic beds, and minimum-security clients are treated in general adult psychiatric units at other state facilities.

But during the fiscal 1983, three problems increasingly pressed mental health and/or corrections officials: criminal commitments were outstripping the mental health department's capacity at Biggs; prison overcrowding was forcing state officials to contemplate quick conversion of underused state facilities to prisons; and the tension from overcrowding was exacerbated by the lack of mental health care.

On each point, the Mental Health Commission and department took the initiative.

The capacity of Biggs can't be increased without new construction because of a 1980 federal court order that cut the number of beds by one-third to 215. So Governor Bond and mental health officials successfully sought

administrative agents

Service Area	Agent (Main Location)	Per Capita Funding, 1983
1	St. Joseph State Hospital	$ 6.09
2	Western Missouri MHC (Kansas City)	9.25
3	Swope Parkway MHC (Kansas City)	6.35
4	Community MHC (Kansas City)	3.48
5	Comprehensive MH Services (Independence)	3.06
6	Tri-County MHC (North Kansas City)	2.44
7	West Central Missouri MHC (Warrensburg)	1.50
8	Nevada State Hospital	1.32
9	Ozark Community MHC (Joplin)	3.09
10	Burrell MHC (Springfield)	4.93
11	Family MHC (Jefferson City)	1.50
12	Mid-Missouri MHC (Columbia)	5.52
13	North Central Missouri MHC (Trenton)	1.50
14	Mark Twain MHC (Hannibal)	3.72
15	Fulton State Hospital	2.65
16	Four County MH Services (St. Charles)	2.81
17	Farmington State Hospital	2.76
18	Ozark Area Care & Counseling (Houston)	1.50
19	Southeast Ozark MHC (Poplar Bluff)	1.50
20	Bootheel MH Services (Sikeston)	1.50
21	St. Francis MHC (Cape Girardeau)	4.07
22	Comtrea Community Treatment (Festus)	1.50
23	Great Rivers MH Services (Clayton)	0.54
24	Yeatman/Union-Sarah Health Center (St. Louis)	5.18
25	Malcolm Bliss MHC (St. Louis)	10.14
26	St. Louis State Hospital	5.11

Number	Facility (Location)
27	Hawthorn Children's Hospital (St. Louis)
28	Woodson Children's Hospital (St. Joseph)

planning funds in the 1982 special legislative session for an 80-bed addition to the center.

The department agreed to provide staff for the addition if the Department of Corrections split all costs, including construction money from the $600 million state bond issue for buildings. Yet to come are funds to actually construct the $5.2 million complex in Fulton. The department is seeking that appropriation in the October 1983 special session.

the Farmington conversion

The department and commission remained cognizant of the need to decrease a physical plant that, on the average day, housed more than 80 percent fewer clients than before the community mental health movement began. At the same time, the corrections department desperately needed extra beds as quickly as possible for a system accommodating 40 percent more inmates than the design capacity.

The commission in 1981 authorized an outside study of the feasibility and impact of eliminating a psychiatric facility. Delivered the next year, the report by University of Missouri faculty identified Farmington and St. Joseph state hospitals as the most cost-effective targets for closing.

the compromise: a new hospital in exchange for a prison

But conscious of the need for access to psychiatric beds in southeast Missouri -- which Farmington serves -- the Mental Health Commission proposed a compromise: the department would turn over the Farmington campus to corrections for a relatively inexpensive and quick prison conversion in exchange for a new $15.3 million, 170-bed hospital in Farmington.

The department also would operate an 89-bed acute forensic hospital in an existing Farmington building, complementing the capabilities of Biggs and Cremer. Finally, the commission vowed to seek future funding of contracts with private agencies for 30 acute psychiatric beds in sprawling southeast Missouri to increase general access.

The General Assembly approved $819,000 to plan that conversion in a 1983 supplemental appropriation. But initial construction funding failed to reach a final vote in the 1983 regular session. The commission and department will again seek funding for the first phase during the 1983 special session.

Tensions within the corrections system weren't held at bay by debate over possible improvements. The broiling summer of 1983, marked by guard and inmate deaths at a Moberly prison, prompted emergency proposals to deal with overcrowding and understaffing.

Prison officials estimated 800 inmates -- or one in 10 -- needed psychiatric treatment and, of those, 300 cases warranted inpatient care. To illustrate the seriousness of the problem to the understaffed corrections system, officials suggested that the troubled 10 percent occupied 80 percent of the staff's time.

The commission responded by asking that 200 beds be set aside for a residential treatment center for medium-

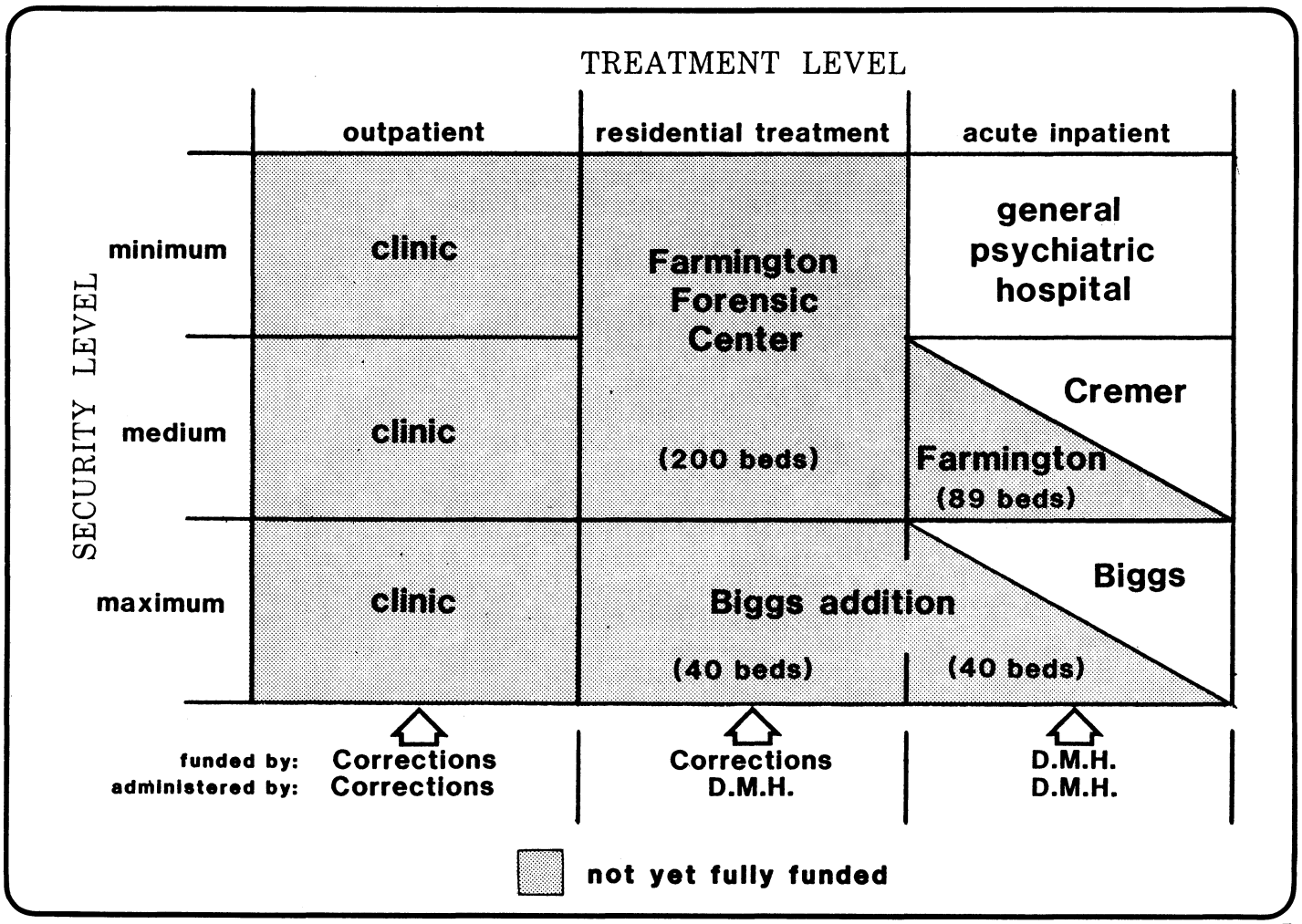
and minimum-security inmates in the Farmington hospital conversion plan. While the change would decrease the prison's capacity somewhat, the segregation of these mentally ill inmates would reduce strains within the system. The Department of Mental Health would provide the staffing for the center, but the Department of Corrections would fund the project, under the commission's proposal.

Combined with Biggs, the Biggs addition, Cremer, the 89-bed acute hospital and 30 psychiatric beds at the main penitentiary hospital in Jefferson City, the Farmington plan should meet the demand for acute and residential treatment in the prison system for several years.

The commission also endorsed the establishment of psychiatric outpatient clinics at each corrections facility. Mental health personnel there, hired by the corrections department, would make sure that inmates continue to take their stabilizing medications and avoid rehospitalization. The Department of Corrections followed suit by announcing that it will seek funding of 54 mental health professionals during the 1983 special session.

Finally, the disparate forensic proposals -- often bewildering to the outside observer -- were drawn together in a master forensic plan proposed by Director Ahr. The plan provides for a comprehensive system of psychiatric care for the corrections system, depending on the treatment needs and security requirements of clients.

at last, a plan to help the mentally ill inmate



a historical profile of the department

The Department of Mental Health served more than 90,000 Missourians with its budget of $242.8 million and 10,454 employees in fiscal 1983.

Before 1921, each facility was managed by an independent board of trustees that appealed separately to the legislature for funding.

The department, originally the State Eleemosynary Board, then was created to provide "humane and safe treatment, to secure the highest degree of individual development for the wards of the state, to secure systematic and uniform management, to attain the highest degree of economy consistent with the standards to be maintained and, finally, to promote the study of mental, physical, and moral defect with a view to cure or prevention."

In 1946, the duties of the State Eleemosynary Board were assumed by the Division of Mental Diseases of the Department of Public Health and Welfare. The division was established by statute after adoption of the 1945 Missouri Constitution.

The State Mental Health Commission was created on August 29, 1957, with five members appointed by the governor with the advice and consent of the Senate. In 1965, the membership was increased from five to the present seven. The commission appoints the department director, with the advice and consent of the Senate, and serves in an advisory capacity to the director in establishing standards for the department's operation.

Fulton was the first state psychiatric facility west of the Mississippi

In 1959, the legislature first authorized and funded a community placement program as a residential alternative to care in large institutions. From 150 clients served initially, mostly in nursing homes, the program has increased to serve about 8,500 clients in varied settings.

The Department of Mental Health became one of 14 Cabinet-level state departments under the Omnibus Reorganization Act of 1974, which implemented earlier constitutional provisions. This act also created the Division of Mental Retardation and Developmental Disabilities within the department.

In 1980 the Division of Alcohol and Drug Abuse and the Division of Comprehensive Psychiatric Services were created. Also established were the State Advisory Council on Client Affairs, which advises the department director on client rights and procedures, and the Professional Review Committee, which monitors research on department clients.

The Division of Alcohol and Drug Abuse contracts for services rather than providing direct rehabilitation. In 1970 and 1972, federal legislation had required every state to begin a program to combat and treat substance abuse. Missouri governors had assigned that responsibility to the department until the legislature affixed the duty by statute in 1980.

The Division of Comprehensive Psychiatric Services

supervises the operations of five state hospitals, three mental health centers, two children's psychiatric hospitals and a mental health services center. This division also contracts for community psychiatric services and residential placement programs.

Fulton State Hospital was the first state psychiatric facility west of the Mississippi River. It opened in 1851 as the state "asylum for the insane." The Biggs Forensic Center, the state's maximum-security unit for criminally-committed patients, is located at Fulton.

In 1861 the St. Louis State Hospital, originally called the County Lunatic Asylum, was begun by St. Louis County. The Civil War intervened, however, and the main building was not completed until 1869. When St. Louis City separated from St. Louis County in 1875, the name was changed to City Sanitarium. In 1948, the city turned the facility over to state control.

St. Joseph State Hospital admitted its first patient in 1876 followed by Nevada State Hospital in 1887. Farmington State Hospital opened in 1902, the same year that the designation "state hospital" was adopted for each facility to replace the earlier "asylum for the insane."

In 1938, Malcolm Bliss Mental Health Center was established by St. Louis City. It was transferred to the state in 1964 and dedicated in 1967 as a state-operated community mental health center to provide short-term intensive psychiatric treatment.

Western Missouri Mental Health Center began operating in 1954 as the "Psychiatric Receiving Center" of the Greater Kansas City Mental Health Foundation. In 1963, the center was transferred to the city and then the state in 1966.

Mid-Missouri Mental Health Center in Columbia was established in 1967 as the first community mental health center founded under a federal law providing funds to build those facilities.

In 1981, the department recognized as separate facilities the Woodson Children's Psychiatric Hospital, formerly part of St. Joseph State Hospital, and the Hawthorn Children's Psychiatric Hospital, formerly part of St. Louis State Hospital.

the school-hospitals were renamed habilitation centers

In 1983, the department established Great Rivers Mental Health Services to provide evaluation and purchase private treatment services for citizens of St. Louis County.

The Division of Mental Retardation and Developmental Disabilities supervises the operations of four large habilitation centers, St. Louis Developmental Disabilities Treatment Center and 11 regional centers. The habilitation centers previously operated as state school-hospitals, but the department renamed those facilities in 1983 to meet the requirements of national accrediting authorities and to more accurately reflect the mission. The division also contracts for community services and a placement program.

Marshall Habilitation Center, opened in 1901, was the first facility in the state to serve solely the mentally retarded.

Bellefontaine Habilitation Center in St. Louis County was established by St. Louis City in 1924. The facility was transferred to the state in 1948. In 1975, it became the first facility in Missouri certified as an intermediate care facility for the mentally retarded and, therefore, eligible to receive federal Medicaid reimbursement. The other habilitation centers and St. Louis Developmental Disabilities Treatment Center were certified for Medicaid in 1976.

In 1956, Higginsville Habilitation Center was founded as a branch of the Marshall facility at the site of the former state Confederate Veterans Home. The unit became a separate facility in 1970. In 1973, Nevada Habilitation Center was established on the grounds of Nevada State Hospital.

Central Missouri Regional Center moved to Columbia

In 1975, St. Louis Developmental Disabilities Treatment Center was opened on the grounds of St. Louis State Hospital to provide programs to persons with severe multiple, physical and mental disabilities. In 1983, the center began operating at two other locations in the St. Louis area.

In 1967, four regional centers were established at Albany, Hannibal, Joplin and Springfield. In 1968, four more regional centers were added in Rolla, Kirksville, Poplar Bluff and Sikeston. The Kansas City Regional Center was founded in 1970.

In 1973, the St. Louis Regional Center was begun as a model for the entire division by purchasing rather than providing diagnostic and habilitation services. All of the other regional centers now have funding available to purchase services, which are monitored by division case managers assigned to every client referred by the state.

Central Missouri Regional Center was established in 1975 and located on the grounds of Marshall Habilitation Center. Now operating on the St. Louis model of purchased services only, the center moved in 1982 to Columbia.

The regional centers were initially designated as "diagnostic clinics." They now serve as the entry-and-exit points for the eleven service regions in the Division of Mental Retardation and Developmental Disabilities.

The department and division administrative offices, known as the "central office," are located in Jefferson City.

collecting a fair share for the treasury

Fiscal 1983 was marked by a sharp increase in department collections for the state general revenue fund, but another round of withholdings from appropriations to facilities and community programs.

The department exceeded its most optimistic expectations when year-end reports showed that 1983 revenue collections had increased $11.6 million, or 25.2 percent, over the previous year.

Such collections are returned to the state treasury without directly benefiting department programs. Instead, all state agencies and local aid programs, such as the public schools, gain from the increase during times of tight budgets and severe cash-flow problems.

Final 1983 figures showed the department collected $57.4 million, up from $45.8 million the previous year. It is important to note that these collections don't reflect client or third-party payments to private agencies providing services under state contract. The state merely covers what the client can't afford to pay, according to a formula that takes into account other financial responsibilities and income.

But even without counting such funds, the department in 1983 returned 28 percent of its available appropriations back to the treasury in collections. In other words, the department's true cost to taxpayers is only three-fourths of the appropriated total.

collections exceeded the most optimistic projections

the Medicaid plan

The growth in mental health collections was spurred largely by increased billings to the federal government under the Medicaid program. The total Medicaid reimbursement went up 27 percent to $39.4 million. But the department also registered increases in all other categories, including private pay (17 percent) and insurance (40 percent).

The Medicaid increases reflected the early payoff from the department's new Medicaid conversion plan, which ultimately could return as much as $18 million a year to the state for costs that previously were borne totally by the Missouri taxpayer.

Working with the Department of Social Services, which oversees the joint federal-state Medicaid program in Missouri, the department developed the plan in the third quarter of fiscal 1983. It essentially moves certain programs into the physician's services section of the state Medicaid plan, which sets out which medical costs for the indigent are eligible for coverage. The federal government then reimburses 60 percent of the cost.

The conversion plan relies heavily on charging the federal government for annual assessments and ongoing habilitation of developmentally disabled clients served

in the 11 regional centers. With a quicker-than-expected start, the centers were able to document billings that will earn more than $900,000 during fiscal 1983's fourth quarter, which ended June 30. The plan should allow regional centers alone to bill for $8 million to $12 million a year when fully implemented.

the federal government now bears more of the funding burden

The plan also provides for the department to bill for strictly medical services at all facilities as well as care for low-income children and youth in psychiatric hospitals and habilitation centers. Medicaid reimbursements increased substantially at Fulton and Farmington state hospitals for the mentally ill and habilitation centers at Marshall, Nevada, Higginsville and St. Louis.

The General Assembly made $1.8 million available for fiscal 1984 for the department to add the accounting and treatment personnel to fully implement the Medicaid plan. And while the department doesn't directly benefit from the federal reimbursements, the General Assembly likewise spared the department from deeper cuts in 1984 appropriations requests because of the expected upturn in collections.

a collection package

The Medicaid conversion plan, however, is only one segment of the revenue-collection package that the department has adopted. Among other measures:

--The department is checking male and female clients in community placement on whether they are eligible for Veterans Administration benefits that could total $810 a month. Identifying those benefits can substantially reduce state costs because the department uses its own funds to pay for placements only as a last resort.

--The department is participating in the state debt-offset program, which allows agencies to intercept the Department of Revenue income tax refund of a person who owes the state money.

increased collections eased the extent of budget reductions

--The department has revised its test for determining a client's ability to pay, substantially increasing the amount collected for outpatient services.

--The department is developing a link with the Division of Family Services computer files and Department of Revenue drivers license files so that mental health can check for Medicaid eligibility and locate persons with delinquent accounts.

--A private accounting firm has been retained to identify and bill for Medicare-eligible recipients who were not identified as such when services were provided.

the budget

The department experienced an 8.4 percent increase in its general revenue funding in 1983, thanks to the governor's decision to recognize the collections upturn and keep withholdings to a minimum.

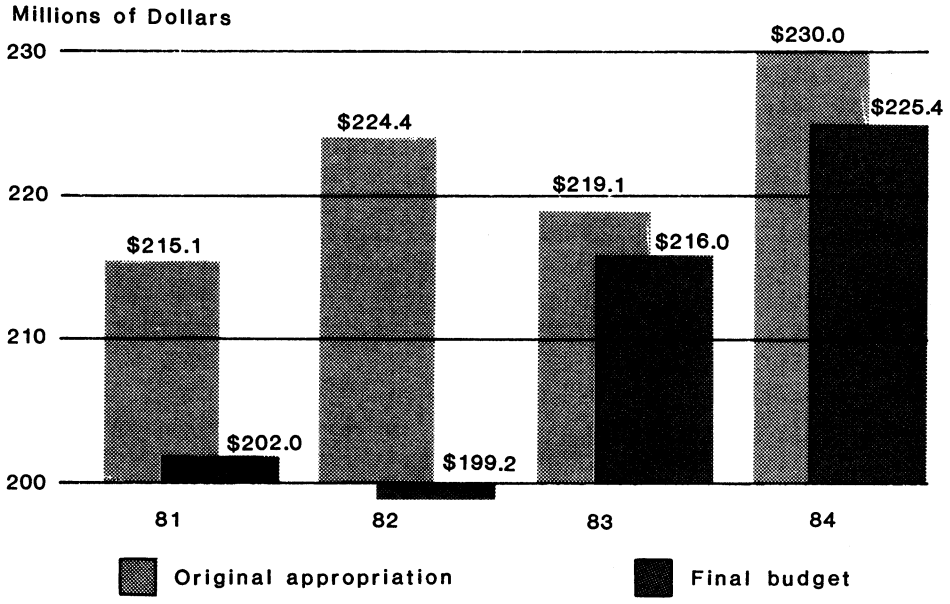
The department's fiscal health has suffered unavoidably from the state's recessionary woes because the agency is so heavily dependent on general revenue. Of

total 1983 appropriations of $242.8 million, the department looked to general revenue for $219.2 million.

The governor directed the department to forgo spending $3.2 million in October 1982 to help the state deal with its cash-flow problems. But the reduction was moderate compared to vetoes and withholdings that totaled $25.2 million in fiscal 1982 and $13.6 million in 1981.

The federal government, through block grants and the former Title XX program, contributes about 10 percent of department spending. The money, with few exceptions, underwrites community-based programs rather than state facilities.

budget reductions



monitoring the quality of care

The Mental Health Commission, in its Mexico plan, reaffirmed that gaining national professional organizations' approval of state facilities remains among the top priorities of the department.

While the department is implementing standards for non-state psychiatric and development disabilities facilities, it must rely on these national organizations to provide an independent assessment of the quality of treatment and habilitation provided in state-operated programs.

Of the 27 state facilities for the mentally ill and developmentally disabled, only six are fully accredited by national organizations.

Higginsville became the first large habilitation center to obtain accreditation

The Accreditation Council for Services for the Mentally Retarded and Other Developmentally Disabled Persons (AC MRDD) has approved the Kirksville Regional Center and Higginsville Habilitation Center for two-year periods.

Higginsville broke new ground in 1983 by becoming the first of the five intensive care facilities for the developmentally disabled to gain accreditation. Springfield Regional Center scored high enough on its 1983 survey to qualify, but awaits official notification.

Missouri Division of Mental Retardation and Developmental Disabilities policy requires that all its 16 facilities gain national approval, and the remainder are seeking fiscal 1985 funding to pay for AC MRDD surveys.

Bellefontaine Habilitation Center, formerly the St. Louis State School-Hospital, was surveyed in January 1983, but the AC MRDD accreditation committee deferred a vote until next year. During the interim, the center is making corrections, and it will apply for a resurvey by January 1984. The surveyors found that the center hadn't taken enough steps to make the program as close to a normal lifestyle as possible -- including changing the name of the facility. More importantly, the center is reorganizing its interdisciplinary teams and procedures for developing, implementing and monitoring the habilitation plans for each client.

six of 27 facilities carry national accreditation

On the psychiatric side, the Joint Commission on the Accreditation of Hospitals (JCAH) has approved Hawthorn Children's Psychiatric Hospital in St. Louis and the three state-operated community mental health centers -- Western Missouri in Kansas City, Mid-Missouri in Columbia and Malcolm Bliss in St. Louis. Both Western Missouri and Hawthorn were accredited for the maximum three-year period.

Fulton State Hospital and Woodson Children's Psychiatric Hospital in St. Joseph both plan to seek JCAH accreditation in fiscal 1984. The proposed 170-bed replacement for Farmington State Hospital should receive JCAH approval soon after it opens in 1986 or 1987. The department will continue to upgrade buildings and programs at St. Joseph and St. Louis state hospitals, but major physical plant improvements are necessary there to

receive accreditation. The department is submitting some of those projects as part of the next phase of the $600 million state bond issue for buildings.

The physical facilities at Nevada State Hospital for the mentally ill, however, are so inadequate that any plan to gain accreditation would be prohibitively expensive. The state and southwest Missouri's mentally ill served by Nevada would benefit more by spending any such funds on constructing a new, efficient hospital.

relying on federal standards

The department doesn't seek accreditation surveys for either psychiatric or developmental disabilities facilities until they were considered to have staffing and physical plants likely to gain national approval.

federal surveyors set staffing standards for treatment

So as a quality control measure and to qualify for partial federal reimbursements of costs, the department's 15 state hospitals, mental health centers and habilitation centers are annually surveyed by Medicare-Medicaid survey teams. The teams check for medical records management, professional staffing levels, dietary conditions, life safety compliance and special staff and laboratory needs.

Each of those facilities has at least part of their beds certified for Medicare-Medicaid reimbursement, and the total number of such beds statewide now exceeds the number of eligible clients that can be expected to occupy them at any given time. Those few Medicaid clients in non-certified beds are assigned there for therapeutic reasons.

The number of psychiatric beds meeting Medicaid standards rose substantially in 1983, climbing 16 percent to 1,229. Facilities for the developmentally disabled increased their Medicaid bed count to 1,796, or 13 percent, and maintained 48 beds certified for Medicare reimbursement at Nevada and Marshall.

the number of Medicaid-certified beds is climbing

All state facilities retained their certification during the fiscal year. The department, however, was forced to revamp the organizational structure and to spend more than $400,000 to cover staffing deficiencies at St. Joseph State Hospital.

Nevada State Hospital received a notice of pending decertification as the fiscal year drew to a close. Hospital officials filed a plan of correction, which provided for hiring more treatment staff, during early June. Nevada officials expected to learn in late September whether they have made enough progress to avoid decertification.

setting standards for non-state programs

The development of local and private psychiatric and developmental disabilities programs have far outstripped the state's ability to monitor the quality of care there.

The life-safety standards of such residential facilities as nursing and boarding homes are checked by the Division of Aging, but assuring the quality of care falls to the department.

the department has responsibility for checking quality of non-state care

That responsibility falls into two categories: certification, which allows a program to do business with the state; and licensing, which allows it to operate at all.

Since 1974, the department has set licensing standards and inspected residential facilities for the mentally retarded and developmentally disabled. Those standards in 1983 were subjected to their first comprehensive overhaul.

They, for example, now cover semi-independent living programs for the first time. Mobile and modular homes no longer can be used for residential facilities. Rules for foster homes were relaxed, but detailed regulations now set standards for use of restraints, abuse and neglect reports and staff training.

Facilities that don't meet the requirements may obtain a temporary waiver if they have a plan of correction. Eventually, however, they must come into compliance.

The department Office of Planning and Quality Assurance's licensure bureau issued 426 licenses to community facilities and programs in 1983. One was denied, and six received probationary licenses.

The department, as yet, has no certification standards for these developmental disabilities facilities or non-residential day programs. Likewise, no regulations yet cover residential or day programs offered by community psychiatric agencies. But during fiscal 1984, the department will begin enforcing new licensure standards.

certifying alcohol abuse programs

The Division of Alcohol and Drug Abuse must certify those private programs that wish to do business with the state. Those regulations were revised thoroughly and published in the June 1983 Missouri Register.

In 1983, the division certified 76 agencies, some of which operate more than one type of program. Qualifying for certification were 27 detoxification programs, 51 residential treatment units and 50 counseling programs.

The division's regulatory powers also have played a role in the statewide offensive against drunken driving. Working with the Department of Public Safety, the division issued regulations for alcohol or drug-related traffic offender programs, commonly called ARTOP programs.

These provide counseling to offenders who have been referred by local courts or elect to enroll.

managing the fourth-largest work force

Despite major reductions in staffing, the department still ranks as the fourth-largest public or private employer in the state of Missouri. The annual payroll totals $150 million.

The work force decreased 5 percent to 10,454 during the year, reflecting the impact of budget restraints for the third consecutive year. But the department was able to limit layoffs to 151, most resulting from the organizational change that reduced the residential beds in regional centers for the developmentally disabled.

The seven-member Mental Health Commission, appointed by the governor, may hire and remove the department director as well as advise the agency on policy developments and budgeting. That official, in turn, heads the chain of command for all other appointments within the department.

The bulk of department employees work under guidelines established under the state merit system and administered by the Missouri Division of Personnel. The system relies on a system of tests and credentials to produce a qualified roster of candidates for department job openings.

But 541 employees, or about 5 percent of the total, are unclassified workers exempt from merit system regulations on hiring, firing, discipline and promotion.

Women account for two-thirds of the work force. At 26.5 percent of all employees, blacks have been hired at more than twice their proportion of the state's population. Both women and blacks are over-represented in the lower wage classifications.

a troubling pay picture

salary problems are critical for an agency dependent on health professionals

For the third year in a row, department employees suffered from meager pay raises. The personnel services budget was increased only by 1 percent plus $600 for each worker.

With that 1 percent, the department was able to reward 2,358 meritorious workers with a 4.5 percent raise. But the bulk of the department work force made do with only the $600, or $50 a month.

Another 592 employees got a 4.5 percent raise because the state repositioned their job classifications to make them more competitive with private employers.

But no substantial relief is in sight.

For fiscal 1984, workers' base pay increased $20 a month across the board. But because of health insurance premium increases, those employees with dependents actually suffered net pay decreases of $10 a month. No funds were appropriated for merit or probationary increases for veteran and new workers, respectively.

The salary problem has proved especially critical for

a department so heavily dependent on highly trained professionals to provide quality health care. The department's competitors -- private and other public hospitals -- face no such strictures.

Recruitment and retention of health care professionals has emerged as a leading priority for the commission over the next three years.

The department must be able to more effectively recruit speech and language therapists, occupational therapists, licensed practical nurses and, in some areas, registered nurses and physicians.

The agency operates at a distinct disadvantage in such regions as central Missouri, where health care is a major industry and its professionals are highly sought and paid.

other activities

Assisting the department work force in 1983 were more than 5,000 volunteers who logged in excess of 220,000 hours. If the department had had to hire them at the minimum wage of $3.35 an hour, the bill would run to $740,000.

The department successfully applied for an $82,000 federal grant that will allow the agency to prepare staffing standards and improve the management information system.

The groundwork also was laid for implementing a new employee evaluation system in 1984. Essentially, the supervisor and employee begin the period by developing a contract that sets out expectations. The process provides for continuing comments on how the employee's work measures up to those expectations.

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